Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
REBLOZYL (Luspatercept) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **REBLOZYL (Luspatercept).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a Hematology-Oncology Specialist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____
2. Indicate the Member's diagnosis for the requested medication: _____
3. Is the member ≥18 years of age? **AND**
   □ No □ Yes
4. Is the member diagnosed with beta thalassemia or hemoglobin E/beta thalassemia? **AND**
   □ No □ Yes
5. Is there documentation of receiving regular transfusions (defined as 6 or 20 RBC units in the 24 weeks prior to treatment initiation and no transfusion-free period for ≥35 days during that period)? **AND**
   □ No □ Yes
6. Is there documentation of the following?
   a. Number of RBC transfusions within prior 6 months
   b. Baseline hemoglobin

   □ No □ Yes

For Continuation of Therapy, Please Respond to Additional Questions Below:

1. Reassess every 6 months to determine need for continued therapy; therapy should be discontinued if the member meets any of the following criteria:
   a. No clinically meaningful decrease in transfusions on maximum recommended dose
   b. Non-adherence to the medication

   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**